PRIVACY COMPLAINT FORM

File Number:_____

THE INFORMATION YOU PROVIDE HERE WILL REMAIN CONFIDENTIAL TO THE EXTENT POSSIBLE. THE DEPARTMENT OF HEALTH SERVICES MAY NEED TO SHARE THE INFORMATION TO INVESTIGATE YOUR COMPLAINT. ANYONE MAY FILE A COMPLAINT.

You may submit your complaint to either the Department of Health Services or to the U.S. Department of Health and Human Services.

MAIL THIS COMPLETED COMPLAINT FORM TO:	YOU MAY FILE A COMPLAINT WITH THE SECRETARY OF DHHS TO:
PRIVACY OFFICER C/O OFFICE OF HIPAA COMPLIANCE DEPARTMENT OF HEALTH SERVICES P.O. BOX 997413, MS 4700 SACRAMENTO, CA 95899-7413	SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES U.S. OFFICE FOR CIVIL RIGHTS 50 UNITED NATIONS PLAZA, ROOM 322 SAN FRANCISCO, CA 94102

Employees of the Department or employees of the Department's business associates should use the Whistleblower's form (DHS 6243) to file a complaint.

INDIVIDUAL FILING COMPLAINT			
LAST NAME:		FIRST NAME:	MIDDLE INITIAL:
ADDRESS:		CITY/STATE:	ZIP CODE:
DAYTIME TELEPHONE NUMBER: ( )	EVENING TELEPHONE NUMBER: ( )	EMAIL ADDRESS:	BEST HOURS TO REACH YOU:

CONSENT TO DISCLOSE YOUR NAME

PLEASE SELECT ONE OF THE FOLLOWING:

☐ I CONSENT TO MY NAME BEING DISCLOSED TO INVESTIGATE THIS COMPLAINT.

☐ I DO NOT CONSENT TO MY NAME BEING DISCLOSED. PLEASE NOTE THAT NOT USING YOUR NAME MAY HINDER OUR ABILITY TO COMPLETE THE INVESTIGATION.

INFORMATION ABOUT YOUR COMPLAINT

NAME OF THE ORGANIZATION YOUR COMPLAINT IS AGAINST:	NAME OF PERSON YOUR COMPLAINT IS AGAINST:	DATE(S) ACTION(S) OCCURRED:

DETAILS OF THE COMPLAINT:

I HAVE REASON TO BELIEVE THAT ONE OR MORE OF THE FOLLOWING HAS OCCURRED:

- ☐ THE ORGANIZATION/PERSON HAS INAPPROPRIATELY DISCLOSED MY PROTECTED HEALTH INFORMATION.
- ☐ THE ORGANIZATION/PERSON HAS INAPPROPRIATELY USED MY PROTECTED HEALTH INFORMATION.
- ☐ THE ORGANIZATION/PERSON HAS INAPPROPRIATELY DISPOSED OF MY PROTECTED HEALTH INFORMATION WITHOUT PROTECTING MY PRIVACY.
- ☐ THE ORGANIZATION/PERSON HAS DENIED ACCESS TO MY PROTECTED HEALTH INFORMATION.
- ☐ THE ORGANIZATION/PERSON HAS DENIED MY REQUEST TO AMEND MY PROTECTED HEALTH INFORMATION.
- ☐ THE ORGANIZATION/PERSON HAS DENIED ANOTHER PRIVACY RIGHT.
- ☐ THE ORGANIZATION'S PRIVACY POLICIES AND PROCEDURES VIOLATE THE LAW.

PLEASE PROVIDE A DETAILED DESCRIPTION OF YOUR COMPLAINT COVERING *WHAT, WHEN, WHO, HOW, WHERE,* AND *WHY.* YOU MAY ATTACH ADDITIONAL PAGES IF THERE IS NOT ENOUGH SPACE HERE.

DO YOU HAVE WITNESS(ES)? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF YOUR WITNESSES BELOW:

WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER: ( )
WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER: ( )
WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER: ( )

RESOLUTION OF YOUR COMPLAINT

PLEASE DESCRIBE HOW YOU BELIEVE THAT YOUR PRIVACY COMPLAINT COULD BE RESOLVED:

CONSENT TO REFER YOUR COMPLAINT TO ANOTHER ORGANIZATION

THE DEPARTMENT MAY DECIDE THAT YOUR COMPLAINT DOES NOT VIOLATE THE HIPAA PRIVACY RULE, BUT ANOTHER ORGANIZATION MAY BE ABLE TO HELP YOU. CHOOSE ONE OF THE FOLLOWING:

☐ I AGREE TO HAVE THIS COMPLAINT SENT TO ANOTHER ORGANIZATION.

☐ I DO NOT AGREE TO HAVE THIS COMPLAINT SENT TO ANOTHER ORGANIZATION.

YOUR SIGNATURE

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS CORRECT TO THE BEST OF MY INFORMATION, KNOWLEDGE, AND BELIEF. SIGNATURE:	DATE: